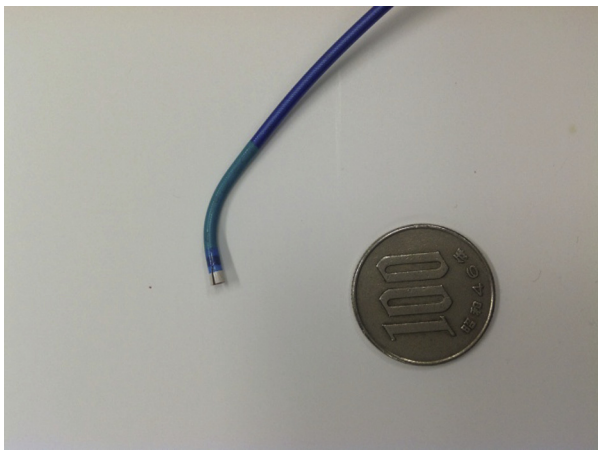
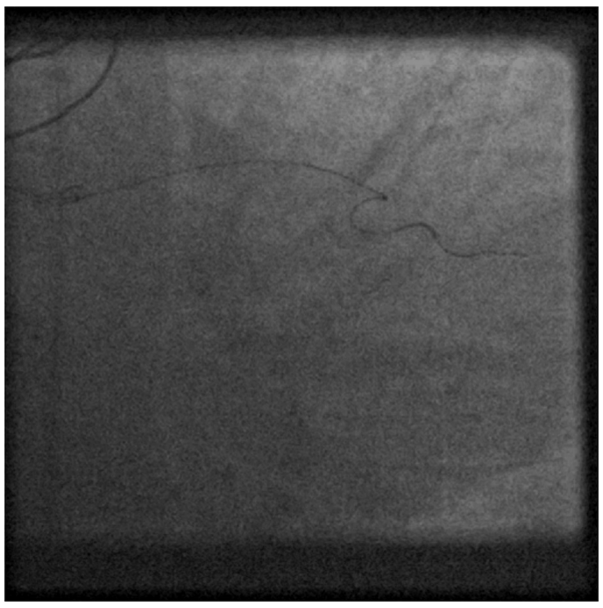


**Case Summary:**
After the procedure, we found that the tip of guiding catheter was damaged by cutting balloon. We will report a stent migration case and the result of some examinations about a guiding catheter damaged by cutting balloon and a ruptured stent delivery balloon.

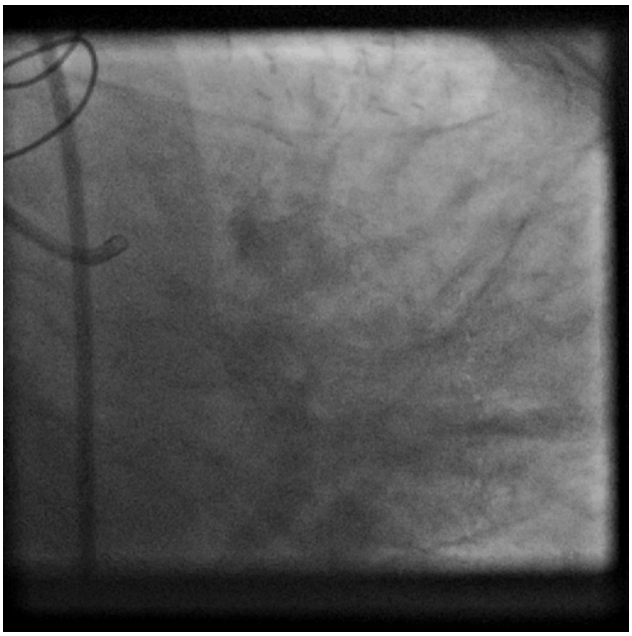


**TCTAP C-153**

**Stride Micro-catheter for Tortuous Diagonal Angioplasty**

*Maddury Jyotsna*
*Nizam's Institute of Medical Sciences, India*

**[Clinical Information]**
**Patient initials or identifier number:**
F4397/2013
**Relevant clinical history and physical exam:**
79 yr old female pt undergone CABG in 2002 with LIMA to LAD and SVG to D1. In 2010 had USA, then CAG showed native mid LCX tight stenosis, patent LIMA to Lad and occluded SVG to D1. Then PCI to LCX with DES was done and attempted to D 1 angioplasty, but failed. Now on maximal medical therapy Pt. come with CSA – AP cl2.
**Relevant test results prior to catheterization:**
ECG showed NSR with ST depression in lateral leads. LV function was normal on 2D Echocardiogram. TMT was positive for inducible ischemia in stage 2.
**Relevant catheterization findings:**
CAG showed patent stent in LCX and LIMA to LAD. D1 is very large vessel with ostial 80% stenosis followed by tortuous 2.5 mm vessel with complete loop immediately after the proximal segment stenosis. SVG to to D1 blocked.
**[Interventional Management]**
**Procedural step:**
As first attempt 3 yrs back was a failure and as there is significant tortuosity, the risk of vessel dissection and closure while crossing the lesion were explained to the pt. Judkin's left 3.5 guide through femoral route was used to engage the left coronary system. As softer wire can negotiate the tortuosity, first ATW wire was tried, but it buckled in proximal D1 and not able to further advance. Balloon support was not helpful. Stride micro catheter (Ashahi, 2,2F) with stabilizer plus wire could cross the proximal lesion but negotiation of 360 degrees loop was difficult. Close proximity of micro catheter to wire in different views and advancing wire with micro catheter mm by mm, facilitated the advancement of the wire. We thought that the coronary wire may not give good support for delivery of stent in this loopy vessel, after reaching the distal bifurcation site, Choice PT wire was exchanged for Stabilizer with micro catheter and micro catheter was removed by Nanto technique. 2.5x28mm Promus element plus stent was deployed from ostium to prox D1 with good result.



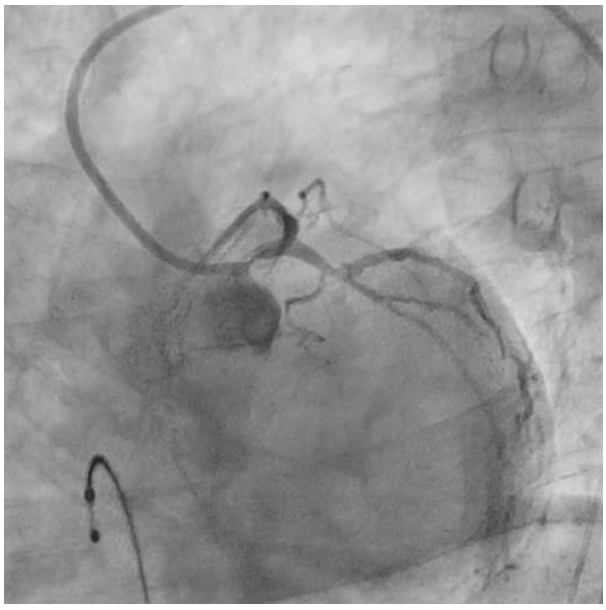
**TCTAP C-154**

**Leriche Syndrome: Subintimal Dissection and Re-entry Technique**

*Linda Lison, Teguh Santoso, S. G. Kang*
*Medistra Hospital, Indonesia*

**[Clinical Information]**
**Patient initials or identifier number:**
Mr. S
**Relevant clinical history and physical exam:**
Intermitten Claudicatio, fatique leg, importance, history of nephectomy and PCI
Inpalpalble pulses of lower extremity,
ECG: old anterio-septal MCI
Chest X ray and Physical Examination unrevealing
Echocardiographie: Hypokinetic in anterior septal wall, LV EF 54%
**Relevant test results prior to catheterization:**
MSCT Scan:
Total occlusion of the abdominal aorta
Single (left) renal artery (post-right nephrectomy)
Collaterals from the superior & inferior mesenteric arteries and intercostal/subcostal arteries to the hypogastric arteries, retrogradely supplying the common iliac arteries.

**Relevant catheterization findings:**
Total Occlusion of the abdominal aorta
Total Occlusion of the left and right iliac arteries close to it origin
Rich of collateral
**[Interventional Management]**
**Procedural step:**
Approach through left a. brachial and bilateral left and right a. Femoral. In angiography total occlusion Aorta abdominalis appears along t > 10 mm and total occlusion in left and right a. Iliaca in the proximal segment. Micro guide wire 300 cm with a micro-catheter support CXL could not pass proximal cup occlusion stamp into aorta abdominal. Terumo guide wire could be pass through occlusion of the aorta abdominal using the sub-intimal passage technique into left a. Iliaca. And then used externalization with snare wire kid. Furthermore, tried to passed through the occlusin of aorta abdominal from the right a. Iliaca to cross the sub-intimal passage using Guide wire technique, but could not pass through proximal stamp. Then an attempt were made through a penetration using the catheter of left a Iliaca cup and then gradual dilatation and implanted the stent-graft Hercules Pyloric 20/80 mm into the abdominal aorta through the proximal cup. Furthermore Terumo guide wire can be passed through the lumen of the stent graft and the aorta abdominal to aorta-thoracal. Did the kissing balloon dilatation and implanted 2 stent graft Absolute Pro LL (120/8 cm to right a. iliaca and 150/8 cm to left a. iliaca) with final kissing stent technique and satisfactory final result.
**Case Summary:**
A case of Leriche syndrome is described.
Subintimal disecction and re-entry technique can be applied to create recanalization to facilitate stenting procedures.



**TCTAP C-155**

**Simultaneous Coronary and Valvular Intervention**

*Srinivas Matha*
*Narayana Hrudayalaya Hospital, India*

**[Clinical Information]**
**Patient initials or identifier number:**
Dr.SM
**[Interventional Management]**
**Procedural step:**

- Echo revealed RWMA of LV post wall,LVEF of 50%, preserved right ventricular function, MAC+ with mild MR, mild-mod TR with mod PAH, a heavily calcified tri-leaflet aortic valve with severe AS, a max gradient of 100 mm Hg with a mean gradient of 64 mm Hg, and an aortic valve area of 0.8 cm2.
- Pt was taken up for CAG under TPI & IABP support with a plan for AVR + CABG.

**Case Summary:**

- 74 years male, diabetic, smoker
- CAD- UA, s/p PTCA+ stent to LAD (02/97), good LV function, mild AS, +ve TMT (11/10)
- Had rest angina with ECG changes X 2wks
- Had cardiac arrest in the hospital while climbing stairs, was mech ventilated & resuscitated
- ECHO Showed severe Calcific Aortic Stenosis
- Underwent CAG which revealed critical LMCA Stenosis

Underwent Successful PTCA + Stenting of Critical LMCA Stenosis along with Percutaneous Aortic Balloon Valvuloplasty.